COMMONWEALTH OF VIRGINIA

STATE CORPORATION COMMISSION

AT RICHMOND, OCTOBER 26, 2001

COMMONWEALTH OF VIRGINIA

At the relation of the

STATE CORPORATION COMMISSION

. CASE NO. INS010270

Ex Parte: In the matter of
Adopting Revisions to the Rules
Governing Health Maintenance
Organizations

ORDER TO TAKE NOTICE

WHEREAS, § 12.1-13 of the Code of Virginia provides that the Commission shall have the power to promulgate rules and regulations in the enforcement and administration of all laws within its jurisdiction, and § 38.2-223 of the Code of Virginia provides that the Commission may issue any rules and regulations necessary or appropriate for the administration and enforcement of Title 38.2 of the Code of Virginia;

WHEREAS, the rules and regulations issued by the Commission pursuant to § 38.2-223 of the Code of Virginia are set forth in Title 14 of the Virginia Administrative Code;

WHEREAS, the Bureau of Insurance has submitted to the Commission a proposed revision to Chapter 210 of Title 14 of the Virginia Administrative Code entitled "Rules Governing Health Maintenance Organizations," which amends the rule at 14 VAC 5-210-70;

WHEREAS, the proposed revision clarifies that the provisions of subsection C of 14 VAC 5-210-70 do not apply to certain Family Access to Medical Insurance Security (“FAMIS”) Plans that are underwritten by a health maintenance organization; and

WHEREAS, the Commission is of the opinion that the proposed revision should be considered for adoption with a proposed effective date of December 1, 2001;

THEREFORE, IT IS ORDERED THAT:

(1) The proposed revision to the "Rules Governing Health Maintenance Organizations," which amends the rule at 14 VAC 5-210-70, be attached hereto and made a part hereof;

(2) All interested persons who desire to comment in support of or in opposition to, or to request a hearing to oppose the adoption of, the proposed revision shall file such comments or hearing request on or before November 26, 2001, in writing with the Clerk of the Commission, Document Control Center, P.O. Box 2118, Richmond, Virginia 23218 and shall refer to Case No. INS010270;

(3) If no written request for a hearing on the proposed revision is filed on or before November 26, 2001, the Commission, upon consideration of any comments submitted in support of or in opposition to the proposed revision, may adopt the revision proposed by the Bureau of Insurance;

(4) AN ATTESTED COPY hereof, together with a copy of the proposed revision, shall be sent by the Clerk of the Commission to the Bureau of Insurance in care of Deputy Commissioner

Gerald A. Milsky, who forthwith shall give further notice of the proposed adoption of the revision to the rules by mailing a copy of this Order, together with a draft of the proposed revision, to all persons licensed by the Commission to transact the business of a health maintenance organization in the Commonwealth of Virginia; and by forwarding a copy of this Order, together with a draft of the proposed revision, to the Virginia Registrar of Regulations for appropriate publication in the Virginia Register of Regulations; and

(5) The Bureau of Insurance shall file with the Clerk of the Commission an affidavit of compliance with the notice requirements of paragraph (4) above.

STATE CORPORATION COMMISSION
BUREAU OF INSURANCE

CHAPTER 210.

RULES GOVERNING HEALTH MAINTENANCE ORGANIZATIONS.

14VAC5-210-70. General requirements.

A. Conversion of coverage.

1. Each health care plan shall offer to its enrollees, upon termination of coverage under a group or individual contract, the right to convert coverage, within 31 days after such termination of coverage, to an individual contract. Such converted coverage:

a. Shall provide benefits which, at a minimum, meet the requirements set forth in subsection B of 14 VAC 5-210-90 of this chapter; and

b. Shall not be refused on the basis that the enrollee no longer resides or is employed in the health maintenance organization's service area.

2. The conversion contract shall cover the enrollee covered under the group or individual contract as of the date of termination of the enrollee's coverage under such contract. Coverage shall be provided without additional evidence of insurability, and no preexisting condition limitations or exclusions may be imposed other than those remaining unexpired under the contract from which conversion is exercised. Any probationary or waiting period set forth in the conversion contract shall be deemed to commence on the effective date of coverage under the original contract.

3. A conversion contract shall not be required to be made available when:

a. The enrollee is covered by or is eligible for benefits under Title XVIII of the ~~United States~~ Social Security Act (Public Law 89-97, 79 Stat 286 (July 30, 1965));

b. The enrollee is covered by or is eligible for substantially the same level of hospital, medical, and surgical benefits under state or federal law;

c. The enrollee is covered by substantially the same level of hospital, medical, and surgical benefits under any policy, contract, or plan for individuals in a group;

d. The enrollee has not been continuously covered during the three-month period immediately preceding that enrollee's termination of coverage; or

e. The enrollee was terminated by the health care plan for any of the reasons stated in 14 VAC 5-210-80 B 1 a, b, c, and f of this chapter.

B. Coordination of benefits.

1. A health care plan may include in its group contract or individual contract a provision that the value of any benefit or service provided by the health maintenance organization may be coordinated with any other health insurance or health care benefits or services that are provided by any other group policy, group contract, or group health care plan, including coverage provided under governmental programs, so that no more than 100% of the eligible incurred expenses is paid.

2. A health care plan shall not be relieved of its duty to provide a covered health care service to any enrollee because the enrollee is entitled to coverage under any other policy, contract, or health care plan. In the event that benefits are provided by both a health care plan and another policy, contract, or health care plan, the determination of the order of benefits shall in no way restrict or impede the rendering of services required to be provided by the health care plan. The health maintenance organization shall be required to provide or arrange for the service first and then, at its option, seek coordination of benefits with any other health insurance or health care benefits or services that are provided by any other group policy, group contract, or group plan.

C. Copayments.

1. A health maintenance organization may require a copayment of enrollees as a condition for the receipt of specific basic health care services described in subsection B of 14 VAC 5-210-90 of this chapter. Such copayments shall be shown in the evidence of coverage as a specified dollar amount or as a percentage of the cost of providing such service for each specific basic health care service for which the health maintenance organization requires a copayment. The maximum amount of copayment the health

maintenance organization may require in any contract or calendar year shall not exceed 200% of the total annual premium per single member or family unit. The maximum copayment amount shall be based upon the actual premium charged, including any employer contributions, for that member or family's coverage. The maximum copayment amount shall be shown in the evidence of coverage as a specified dollar amount.

2. A health maintenance organization may impose other copayments for supplemental health care services than those specified in this subsection.

3. Each health maintenance organization shall keep accurate records of each enrollee's copayment expenses and notify the enrollee when his copayment maximum is reached. Such notification shall be given no later than 30 days after the copayment maximum is reached. The health maintenance organization shall not charge additional copayments for the remainder of the contract or calendar year, as is appropriate. The health maintenance organization shall also promptly refund to the enrollee any copayments charged after the copayment maximum is reached. The evidence of coverage shall clearly state the health maintenance organization's procedure for meeting the requirements of this subsection.

4. The provisions of this subsection shall not apply to any Family Access to Medical Insurance Security (FAMIS) Plan (i) authorized by the United States Centers for Medicare and Medicaid Services pursuant to Title XXI of the Social Security Act (42 U.S.C. § 1397aa et seq.) and the state plan established pursuant to Chapter 13 (§ 32.1-351 et seq.) of Title 32.1 of the Code of Virginia and (ii) underwritten by a health maintenance organization.

D. Description of providers. A list of the names and locations of all affiliated providers shall be required to be provided to subscribers by the health maintenance organization at the time of enrollment or at the time the contract or evidence of coverage is issued and shall be made available upon request or at least annually.

E. Description of service area. A description of the service area within which the health maintenance organization shall provide health care services shall be required to be provided to subscribers by the health maintenance organization at the time of enrollment or at the time the

contract or evidence of coverage is issued and shall be made available upon request or at least annually.

F. Extension of benefits.

1. Every group contract issued by a health maintenance organization shall contain a reasonable extension of benefits upon discontinuance of the group contract with respect to members who become totally disabled while enrolled under the contract and who continue to be totally disabled at the date of discontinuance of the contract.

2. Upon payment of premium, coverage shall remain in full force and effect for a reasonable period of time not less than 180 days, or until such time as the member is no longer totally disabled, or until such time as a succeeding carrier elects to provide replacement coverage to that member without limitation as to the disabling condition.

3. Upon termination of the extension of benefits, the enrollee shall have the right to convert coverage as provided for in subsection A of this section.

G. Freedom of choice.

1. At the time of enrollment each enrollee shall have the right to select a primary care physician from among the health maintenance organization's affiliated primary care physicians, subject to availability.

2. Any enrollee who is dissatisfied with his primary care physician shall have the right to select another primary care physician from among the health maintenance organization's affiliated primary care physicians, subject to availability. The health maintenance organization may impose a reasonable waiting period for this transfer.

H. Grievance procedure.

1. Each health maintenance organization shall establish and maintain a grievance or complaint system to provide reasonable procedures for the prompt and effective resolution of written complaints. A record of all written complaints shall be maintained for a period of at least three years.

2. Every health maintenance organization shall provide complaint forms and/or written procedures to be given to enrollees who wish to register written complaints. Such forms or procedures shall include the address and telephone number to which complaints

must be directed and shall also specify any required time limits imposed by the health maintenance organization.

3. The grievance system shall provide for complaints to be resolved within a reasonable period of time, not more than 180 days from the date the complaint is registered. This period may be extended (i) in the event of a delay in obtaining the documents or records necessary for the resolution of the complaint, or (ii) by the mutual written agreement of the health maintenance organization and the enrollee registering the complaint.

4. Pending the resolution of a written complaint filed by a subscriber or enrollee, coverage may not be terminated for the subscriber or enrollee for any reason which is the subject of the written complaint, except where the health maintenance organization has, in good faith, made an effort to resolve the complaint and coverage is being terminated as provided for in subsection B of 14 VAC 5-210-80 of this chapter.

5. Where enrollee complaints and grievances may be resolved through a specified arbitration agreement, the enrollee shall be advised in writing of his rights and duties under the agreement at the time the complaint is registered. No contract or evidence of coverage that entitles enrollees to resolve complaints and grievances through an arbitration agreement shall limit or prohibit such arbitration for any claims asserted having a monetary value of $250 or more. If the enrollee agrees to binding arbitration his written acceptance of the arbitration agreement shall not be executed prior to the time the complaint is registered nor subsequent to the time an initial resolution is made, and the agreement must be accompanied by a statement setting forth in writing the terms and conditions of binding arbitration.